DEPARTMENT OF HEALTH SERVICES
714/744 P Street
P. O. Box 942732
Sacramento, CA 94234-7320
(916) 654-0348

October 4, 2002

TO: EXECUTIVE DIRECTOR

SUBJECT: EXPANDED ACCESS TO PRIMARY CARE (EAPC) PROGRAM
NOTICE OF AWARD FOR FISCAL YEAR (FY) 2002-2003

The purpose of this letter is to notify you that your application for continued funding under the EAPC Program for FY 2002-2003 has been approved. Program information and compliance instructions for the current funding period are enclosed with this award package (Enclosures A-D). Enclosure "A" provides a listing of all approved clinic corporations and their awards. Please be advised that you may begin submitting EAPC claims to Electronic Data Systems (EDS) for services provided after July 1, 2002. (Refer to Enclosure "B" Billing Procedures.)

Health and Safety Code, Sections 124900 through 124945 provide the statutory framework for the EAPC program. Specifically, the EAPC program provides reimbursement to primary care clinics for the delivery of expanded outpatient medical services, including preventative health care, and smoking prevention and cessation health education, to program beneficiaries.

Source of funds The EAPC Program allocation for FY 2002-2003 is as follows:

FUNDING SOURCE	AMOUNT
General Fund	$23,500,000
Cigarette and Tobacco Products Surtax (clinical services)	$7,653,000
TOTAL FUNDING	**$31,153,000**

Funding methodology

The steps described below were followed in applying the funding methodology for FY 2002-2003:

1. Continuing participants in the Program received 90 percent of their *FY 2001-2002* award, provided that the award was substantiated by the clinics' reported uncompensated care (UCC) visits. (See UCC definition below.) These awards were made available to all providers on September 20, 2002.

2. The remaining balance ($4,919,549) was divided by the total number of UCC visits (1,638,702) reported by applicants. The result ($3.00 per UCC visit) was distributed on a pro rata basis to applicants as a "needs based adjustment."

3. With input from stakeholders in FY 2000-2001, the Department of Health Services (Department) implemented a minimum base award of $25,000. No successful applicant received an award of less than $25,000.

4. Per Health and Safety Code Section 124900 (d)(6), a minimum of $35,000 was awarded to Native American and frontier clinics.

Uncompensated Care

For purposes of the EAPC Program and funding methodology, "uncompensated care" (UCC) is defined in accordance with Health and Safety (H&S) Code Section 124900(d)(2)(B), as follows:

"…clinic patient visits for persons with incomes at or below 200 percent of the federal poverty level for which there is no encounter-based third-party reimbursement which includes, but is not limited to, unpaid expanded access to primary care claims and other unreimbursed visits as verified by the department…"

Purpose of funds

EAPC funds are to be used to reimburse primary care clinics that provide primary and preventive health care services, including smoking prevention and cessation education to eligible EAPC patients. Reimbursable services must supplement and not supplant services provided to patients that are covered by any county, state or federal program, for example, Medi-Cal and County Medical Services Program (CMSP).

Enclosures

The following attached enclosures provide vital program compliance information and instructions. **Please provide this information to your clinic staff.**

Enclosure "A" provides your corporation's total award amount and your assigned EAPC provider billing number to be used when submitting EAPC claims for reimbursement. Only one EAPC provider number is assigned to each corporation, regardless of the number of clinic sites.

Enclosure "B" provides the EAPC billing procedures and guidelines.

Enclosures "C" provides the Child Health and Disability Prevention (CHDP) Program guidelines and reporting requirements.

Enclosure "D" is a copy of California Health and Safety Code section 124900-124945 that describes the EAPC program requirements and responsibilities.

Department notification

Please provide written notification, *within 30 days of occurrence*, to the EAPC Program should any of the following occur throughout the fiscal year: corporation merger, change of ownership, corporate or clinic name change, any address change or change in telephone number(s).

Contact information

If you have any questions, you may e-mail your inquiry to an EAPC analyst listed below, or call (916) 654-0348.

Name	E-mail Address
Judy Hamilton	jhamilto@dhs.ca.gov
Rita Vargas	rvargas@dhs.ca.gov
Chris Taylor	ctaylor2@dhs.ca.gov

Additional information concerning the EAPC Program may be accessed through the internet at www.dhs.ca.gov/eapc

On behalf of the EAPC program, we thank you for your continued commitment to providing vital health care services to the medically underserved population in your community.

Should you have any questions regarding this letter, please contact Mr. Tony Agurto, Chief, Primary Health Services Development Programs, at (916) 654-0348.

Sincerely,

Sandra (Sam) Willburn, Chief
Primary and Rural Health Care
Systems Branch

Enclosures

cc: (See Next Page)

cc:

Ms. Diane Van Maren
Senior Consultant
Senate Budget and Fiscal
Review Committee
State Capitol, Room 5013
Sacramento, CA 95814

Mr. Michael Dimmitt
Budget Consultant
Assembly Budget Committee
State Capitol, Room 6026
Sacramento, CA 95814

Ms. Therese Tran
Budget Consultant
Senate Republican Fiscal Committee
1020 N Street, Room 580
Sacramento, CA 95814

Ms. Sharon Bishop
Budget Consultant
Assembly Budget Committee
State Capitol, Room 6026
Sacramento, CA 95814

Mr. Arnoldo Torres
Executive Officer
California Hispanic Health Care Association
c/o Torres and Torres
926 J Street, Suite 1016
Sacramento, CA 95814

Ms. Carmela Castellano,
Chief Executive Officer
California Primary Care Association
1201 K Street, Suite 1010
Sacramento, CA 95814

California Rural Indian Health Board
4400 Auburn Blvd., 2nd Floor
Sacramento, Ca 95814

Western Indian Network
4141 State Street, B2
Santa Barbara, CA 93110

Ms. Lisa Folberg
Fiscal and Policy Analyst
Legislative Analyst's Office
925 L Street, Suite 1000
Sacramento, CA 95814

ENCLOSURE A

CALIFORNIA DEPARTMENT OF HEALTH SERVICES
PRIMARY AND RURAL HEALTH CARE SYSTEMS BRANCH

EXPANDED ACCESS TO PRIMARY CARE (EAPC)
FY 2002-03 AWARD AMOUNTS

PROVIDER NUMBER	EAPC CLINIC CORPORATION	FY 2002-03 AWARD
EAP70454F	AIDS HEALTHCARE FOUNDATION	$ 215,707
EAP03923F	ALLIANCE MEDICAL CENTER	$ 177,829
EAP13999F	ALTA FAMILY HEALTH CLINIC	$ 32,183
EAP11568F	ALTAMED MEDICAL GROUP	$ 221,881
EAP70786F	AMERICAN INDIAN HEALTH & SERVICES	$ 44,386
EAP03881F	ANDERSON VALLEY HEALTH CENTER	$ 52,483
EAP70071F	ARROYO VISTA FAMILY HEALTH FOUNDATION	$ 308,944
EAP11641F	ASIAN HEALTH SERVICES	$ 134,438
EAP70733F	ASIAN PACIFIC HEALTH CARE VENTURE	$ 36,495
EAP70883F	BAYVIEW FAMILY HEALTH CENTER	$ 48,767
EAP00004F	BERKELEY COMMUNITY HEALTH PROGRAM	$ 105,315
EAP11969F	BERKELEY WOMEN'S HEALTH CENTER	$ 54,580
EAP70699F	BROOKSIDE COMMUNITY HEALTH CENTER	$ 82,439
EAP70424F	CENTER FOR AIDS RESEARCH	$ 25,000
EAP70570F	CENTER POINT, INC.	$ 37,693
EAP12027F	CHAPA-DE INDIAN HEALTH PROGRAM	$ 289,155
EAP00007F	CHILDREN'S DENTAL FOUNDATION	$ 282,589
EAP70012F	CHINATOWN SERVICE CENTER	$ 50,814
EAP70887F	CITY HELP WELLNESS CENTER	$ 25,000
EAP70090F	CLINICA DE SALUD DEL VALLE DE SALINAS	$ 513,833
EAP70386F	CLINICA MSR. OSCAR A. ROMERO	$ 68,383
EAP70453F	CLINICA PARA LAS AMERICAS	$ 56,088
EAP03895F	CLINICA SIERRA VISTA	$ 1,017,736
EAP03830F	CLINICAS DE SALUD DEL PUEBLO	$ 393,460
EAP70103F	CLINICAS DEL CAMINO REAL	$ 372,133
EAP70434F	COASTAL HEALTH ALLIANCE	$ 66,212
EAP11771F	COMMUNICARE HEALTH CENTERS	$ 593,632
EAP53865F	COMM CHIROPRACTIC HLTH CLINICS OF CALIF	$ 28,239
EAP70768F	COMMUNITY HEALTH ALLIANCE OF PASADENA	$ 62,400
EAP11719F	COMMUNITY HEALTH CLINIC OLE	$ 95,681
EAP70324F	COMMUNITY HEALTH SYSTEMS, INC.	$ 170,596
EAP03884F	COMMUNITY HLTH CTRS OF THE CENTRAL COAST	$ 224,671
EAP70629F	COMMUNITY MEDICAL CENTERS	$ 578,175
EAP70442F	CONSOLIDATED TRIBAL HEALTH	$ 93,829
EAP53824G	COPPER TOWERS FAMILY MED CENTER	$ 89,647
EAP70046F	DARIN M. CAMARENA HEALTH CENTER	$ 291,355
EAP70718F	DEL NORTE CLINICS, INC.	$ 484,969
EAP11503G	DELTA HEALTH CARE & MGMT SERVICES	$ 66,557
EAP70609F	DIENTES COMMUNITY DENTAL CLINIC	$ 53,953
EAP00002F	EAST LOS ANGELES HEALTH TASK FORCE	$ 95,281
EAP11665F	EAST VALLEY COMMUNITY CLINIC	$ 61,496
EAP12048F	EAST VALLEY COMMUNITY HEALTH CENTER	$ 270,145
EAP70092F	EL DORADO COMMUNITY SERVICES	$ 96,613
EAP70468F	EL PROYECTO DEL BARRIO	$ 239,786
EAP11890F	FAMILY HEALTH CENTERS OF SAN DIEGO	$ 927,359
EAP03905F	FAMILY HEALTHCARE NETWORK	$ 526,103

PROVIDER NUMBER	EAPC CLINIC CORPORATION	FY 2002-03 AWARD
EAP11726G	FAMILY PLANNING CENTER OF GREATER L.A.	$ 44,391
EAP00010F	FORT MOJAVE INDIAN TRIBE	$ 35,000
EAP70039G	FRANCISCAN CLINICS	$ 118,243
EAP70262F	GARDNER FAMILY HEALTH CARE NETWORK	$ 547,040
EAP11455F	GOLDEN VALLEY HEALTH CENTER	$ 648,122
EAP70517F	GREATER FRESNO HEALTH ORGANIZATION	$ 25,000
EAP11599F	HAIGHT ASHBURY FREE CLINIC	$ 328,152
EAP70304F	HARBOR FREE CLINIC	$ 69,265
EAP11593F	HEALTH CARE CONCERNS COMMITTEE	$ 87,380
EAP70298F	HEALTH FOR ALL	$ 58,691
EAP03894F	HILL COUNTRY COMMUNITY CLINIC	$ 51,327
EAP00008F	HOLLYWOOD SUNSET FREE CLINIC	$ 308,153
EAP11968F	HUNTINGTON BEACH COMMUNITY CLINIC	$ 261,079
EAP11826F	IMPERIAL BEACH COMMUNITY CLINIC	$ 100,999
EAP11900F	INDIAN HEALTH COUNCIL	$ 201,584
EAP11833F	INDIAN HLTH CTR OF THE SANTA CLARA VALLEY	$ 67,076
EAP70520F	INLAND BEHAVIORAL & HEALTH SERVICES	$ 46,542
EAP03888F	I'SOT	$ 53,508
EAP70521F	JWCH INSTITUTE, INC.	$ 77,165
EAP70361F	KARUK TRIBE OF CALIFORNIA	$ 101,582
EAP11802F	KERN COUNTY ECONOMIC OPPORTUNITY	$ 73,987
EAP11573F	K'IMA: W MEDICAL CENTER	$ 236,104
EAP11447F	LA CLINICA DE LA RAZA	$ 510,028
EAP00011F	LA MAESTRA FAMILY CLINIC	$ 125,502
EAP11948F	LAGUNA BEACH COMMUNITY CLINIC	$ 163,916
EAP70470F	LESTONNAC FREE MED CLINIC	$ 140,440
EAP70474G	LIFELONG MEDICAL CARE	$ 195,052
EAP11672F	LINDA VISTA HEALTH CARE CENTER	$ 71,791
EAP03897F	LIVINGSTON COMMUNITY HEALTH SERVICES	$ 211,447
EAP70034F	LONG VALLEY HEALTH CENTER	$ 87,177
EAP00005F	LOS ANGELES FREE CLINIC	$ 519,227
EAP70031F	LYON MARTIN WOMEN'S HEALTH SERVICES	$ 48,622
EAP70018F	M.A.C.T. INDIAN HEALTH	$ 37,763
EAP03882G	MARIAN COMMUNITY CLINICS	$ 92,563
EAP11975F	MARIN COMMUNITY CLINIC	$ 144,163
EAP11533G	MAYVIEW COMMUNITY HEALTH CENTER	$ 124,264
EAP03967F	MENDOCINO COAST CLINICS	$ 66,754
EAP11882F	MID-CITY COMMUNITY CLINIC	$ 61,612
EAP11005F	MISSION AREA HEALTH ASSOCIATES	$ 389,314
EAP70436F	MISSION CITY COMMUNITY	$ 66,764
EAP70345H	MISSION HOSPITAL'S CAMINO HEALTH CENTER	$ 109,525
EAP03931G	MOBILE MEDICAL OFFICE	$ 25,000
EAP53850F	MOUNTAIN HEALTH & COMMUNITY SERVICES	$ 121,739
EAP03915F	MOUNTAIN VALLEYS HEALTH CENTERS, INC.	$ 106,117
EAP53856F	MT. SHASTA MEDI-CAL CLINIC	$ 34,953
EAP03893F	NATIONAL HEALTH SERVICES	$ 386,913
EAP11998G	NATIONAL MED ASSOCIATION	$ 103,031
EAP70481F	NEIGHBORHOOD COMMUNITY HEALTH CENTER	$ 412,693
EAP70490F	NHAN HOA COMPREHENSIVE	$ 145,155
EAP70225F	NORTH COUNTY HEALTH PROJECT	$ 589,843
EAP11007F	NORTH EAST MEDICAL SERVICES	$ 895,755
EAP11584G	NORTHEAST COMMUNITY CLINIC	$ 359,112
EAP11580F	NORTHEAST VALLEY HEALTH CORPORATION	$ 436,532

PROVIDER NUMBER	EAPC CLINIC CORPORATION	FY 2002-03 AWARD
EAP70081F	NORTHEASTERN RURAL HEALTH	$ 99,767
EAP70538F	NORTHERN VALLEY INDIAN HEALTH	$ 79,136
EAP03892F	OPEN DOOR COMMUNITY CLINICS	$ 571,354
EAP70250F	OPERATION SAMAHAN	$ 243,295
EAP11782F	PEDIATRIC & FAMILY MED CENTER	$ 154,988
EAP10001F	PIT RIVER INDIAN HEALTH	$ 35,792
EAP11417F	PLANN PARENTHD ASSOC MAR MONTE	$ 673,036
EAP11491F	PLANNED PARENTHOOD GOLDEN GATE	$ 328,501
EAP03879F	POTTER VALLEY COMMUNITY HEALTH CENTER	$ 85,441
EAP03906F	REDWOOD COAST MED SERVICES	$ 60,996
EAP03891F	REDWOODS RURAL HEALTH CENTER	$ 162,101
EAP70069G	REPRODUCTIVE HEALTH CARE CENTERS	$ 112,422
EAP03854F	RIVERSIDE/SAN BERNARDINO CNTY INDIAN HLTH	$ 485,422
EAP11697F	ROUND VALLEY INDIAN HEALTH	$ 81,679
EAP11575F	SACRAMENTO URBAN INDIAN HEALTH PROJECT	$ 70,472
EAP53807F	SAGE COMMUNITY HEALTH CENTER	$ 96,279
EAP70246F	SALUD PARA LA GENTE	$ 307,276
EAP70448F	SAMUEL DIXON FAMILY HEALTH CENTER	$ 78,184
EAP03872F	SAN BENITO HEALTH FOUNDATION	$ 177,697
EAP70019F	SAN DIEGO AMERICAN INDIAN HEALTH CENTER	$ 68,267
EAP11425F	SAN FRANCISCO MED CTR O/P IMPROVEMENT PROG	$ 139,781
EAP70736F	SAN JOSE FOOTHILL FAMILY COMMUNITY CLINIC	$ 26,600
EAP18880F	SAN YSIDRO HEALTH CENTER	$ 428,220
EAP70097F	SANTA BARBARA NEIGHBORHOOD CLINICS	$ 213,984
EAP70078F	SANTA CRUZ WOMEN'S HEALTH	$ 52,672
EAP70024F	SANTA YNEZ TRIBAL HEALTH	$ 92,326
EAP11992G	SCRIPPS HEALTH FAMILY HEALTH CENTER	$ 118,619
EAP70382F	SEQUOIA COMMUNITY HEALTH FOUNDATION	$ 130,954
EAP70418F	SHASTA COMMUNITY HEALTH CENTER	$ 124,229
EAP03870F	SHINGLETOWN MEDICAL CENTER	$ 34,461
EAP70780F	SIERRA FAMILY MEDICAL CENTER	$ 26,363
EAP11693F	SIX RIVERS PLANNED PARENTHOOD	$ 59,129
EAP11643F	SONOMA COUNTY INDIAN HEALTH	$ 108,950
EAP53855F	SONOMA VALLEY COMMUNITY HEALTH CENTER	$ 83,303
EAP70236F	SOUTH BAY HEALTH CARE CENTER	$ 145,526
EAP70315F	SOUTH CENTRAL FAMILY HEALTH CENTER	$ 61,852
EAP70010F	SOUTHERN INDIAN HEALTH COUNCIL	$ 151,077
EAP70040F	SOUTHERN TRINITY AREA	$ 37,616
EAP70663F	SOUTHWEST COMMUNITY HEALTH CENTER	$ 77,347
EAP70906F	ST JUDE HOSPITAL INC.	$ 76,907
EAP00001F	ST. JOHN'S EPISCOPAL CHURCH	$ 227,445
EAP70367F	ST. JOSEPH HOSPITAL OF ORANGE	$ 100,645
EAP00006F	ST. VINCENT DE PAUL	$ 366,711
EAP11688F	T.H.E. CLINIC FOR WOMEN	$ 89,753
EAP70738F	TARZANA TREATMENT CENTERS, INC.	$ 25,000
EAP11466F	THE CHILDREN'S CLINIC	$ 97,379
EAP11729F	THE EFFORT, INC.	$ 80,998
EAP11635F	TIBURCIO VASQUEZ HEALTH CENTER	$ 161,992
EAP11576F	TOIYABE INDIAN HEALTH PROJECT	$ 147,281
EAP70603F	TRI-CITY	$ 147,274
EAP53895F	TULARE COMMUNITY HEALTH CLINIC, INC.	$ 35,701
EAP03871F	UNITED HEALTH ORGANIZATION	$ 80,312
EAP80160F	UNITED HLTH CTRS OF THE SAN JOAQUIN VALLEY	$ 378,946

PROVIDER NUMBER	EAPC CLINIC CORPORATION	FY 2002-03 AWARD
EAP11761F	UNITED INDIAN HEALTH SERVICES	$ 163,816
EAP11429F	URBAN INDIAN HEALTH BOARD	$ 135,066
EAP70645F	URDC HUMAN SERVICES CORPORATION	$ 41,967
EAP11974F	VALLEY COMMUNITY CLINIC	$ 228,244
EAP03875F	VALLEY HEALTH TEAM, INC.	$ 116,542
EAP11848F	VENICE FAMILY CLINIC	$ 585,714
EAP70783F	VIETNAMESE COMMUNITY OF ORANGE	$ 43,395
EAP70633H	VISITING NURSE ASSOCIATION FOUNDATION	$ 29,171
EAP11710F	VISTA COMMUNITY CLINIC	$ 526,570
EAP12124F	WATTS HEALTH CENTER	$ 551,847
EAP03887F	WEST COUNTY HEALTH CENTERS, INC.	$ 102,598
EAP11649F	WEST OAKLAND HEALTH CENTER	$ 117,529
EAP03800F	WESTERN SIERRA MED CLINIC	$ 49,475
EAP11908F	WESTSIDE NEIGHBORHOOD CLINIC	$ 101,063
EAP11798F	WESTSIDE WOMEN'S HEALTH	$ 62,056
EAP70848F	WILMINGTON COMMUNITY CLINIC	$ 80,305
EAP11538F	WOMEN'S CLINIC	$ 28,994

EXPANDED ACCESS TO PRIMARY CARE (EAPC) PROGRAM (FY 2002- 2003)

BILLING PROCEDURES

Billing process

EAPC claims submitted for reimbursements are processed through the state's fiscal intermediary, Electronic Data Systems (EDS).

The **Medi-Cal Provider Manual (Part 2 - Billing and Policy for Outpatient Services)** provides detailed information regarding the EAPC billing process and on electronic claim submission. The entire manual is available through the Medi-Cal website at: http://www.medi-cal.ca.gov (click on "Publications").

Reimbursement Rate

The uniform statewide reimbursement rate $71.50 *per visit*. This is an all-inclusive reimbursement rate and covers any medically prescribed ancillary services (i.e., laboratory, pharmacy and x-ray) associated with the visit.

If an amount greater than $71.50 is claimed, the claim will be reduced to $71.50. If an amount less than $71.50 is claimed, only the amount claimed will be paid.

Claim status available on Internet

EAPC providers may now access their billing and claim information through a new EAPC link on the Medi-Cal web site at http://www.medi-cal.ca.gov. To access EAPC information, providers must first submit a "*Medi-Cal Point of Service (POS) Network/Internet Agreement"* form to EDS. Upon approval of the form, EDS will mail the provider a unique Personal Identification Number (PIN) necessary to access the EAPC link on the internet.

To request a network/internet agreement form, contact the POS Help Desk at 1-(800) 427-1295 from 6AM to 12AM seven days a week. You may also obtain a copy of the form through the Medi-Cal Web site (go to "Login Instructions" and click on the Sign Up hyperlink).

Sliding fee

EAPC patients may be assessed a sliding fee charge per visit. Sliding fees charged to the patient must be based on family income and ability to pay. Claims should be submitted for the full $71.50 reimbursement rate per visit, regardless of the amount of the sliding fee assessed to the patient for the visit.

EAPC patients should not be charged in whole or in part for any ancillary services required as a result of the EAPC-billed visit.

Sliding fees may be charged for the treatment of conditions identified in the CHDP assessment. Sliding fees are not considered co-payments.

EAPC procedure codes

The table below provides the procedure codes to be used when submitting EAPC claims for reimbursements of services (claims submitted with any other procedure codes will be denied).

PROCEDURE CODE	DESCRIPTION
Z9700	Medical encounter
Z9701	Dental encounter
Z9702	Medical encounter as a result of a CHDP assessment
Z9703	Dental encounter as a result of a CHDP assessment

Billing deadline

The final billing date to submit EAPC claims for reimbursement of services provided from July 1, 2002, through June 30, 2003, is September 30, 2003.

Reallocation of unexpended funds

Any additional claims submitted to EDS in excess of a corporation's allocation amount will be "suspended." At the end of the fiscal year, all unexpended funds are pooled together and redistributed to those corporations with suspended claims on file.

Eligible patients

Eligible patients are persons at or below 200 percent of the federal poverty level and who have no encounter-based third party payer of primary care services.

Primary care services to patients with limited scope Medi-Cal benefits (e.g., pregnancy or emergency services only), or with an unmet share of cost, may be billed to the EAPC Program. These claims should be submitted using a unique "pseudo" social security number, which consists of the patient's numerical six-digit date of birth (MMDDYY) and the first three letters of the patient's last name. If the patient's last name has less than three letters, use "X" as a placeholder for the 2nd or 3rd letter.

Clinic staff is responsible for determining the patient's eligibility and for documenting the visit in the medical record. In accordance with Title 22, Section 56310(a), patient medical records must be maintained by the clinic for a minimum of three years from the date of the visit.

EDS technical assistance

For technical assistance regarding EAPC billing questions:

ISSUE	RESOURCE	PHONE
EDS Claims Processing	Provider Services Center (billing/claims)	1(800) 541-7747
Electronic Claims Processing	EDS Computer Media Claims Help Desk (electronic billing)	(916) 636-1100

In addition, refer to your **Medi-Cal Provider Manual (Part 2-Billing and Policy for Outpatient Services)** for detailed billing procedures.

EAPC CLINIC SCREEN/TREATMENT/BILLING EXAMPLES

There are two assumptions made regarding the following examples:

1. The child meets all the statutory criteria for treatment.

2. The obligation for treatment services by the clinic is limited to those services it directly provides for other patients (e.g., if the clinic does not provide dental services it has no obligation to provide dental treatment).

1. The county instructs a private provider, in writing, to refer CHDP patients to an EAPC clinic when a condition that requires treatment is identified. The private provider is required to keep a copy of the "instruction" letter on file.

   Billing: The EAPC clinic may bill CTP for services rendered.

2. A private CHDP provider identifies a condition requiring treatment. The private CHDP provider refers the child to an EAPC clinic for treatment. However, the parent does not take the child in for the treatment needed. At a later date, the county CHDP Program contacts the parent and directs the child to an EAPC clinic for treatment as part of its case management responsibilities. The EAPC clinic provides treatment services.

   Billing: The EAPC clinic may bill CTP for treatment services, because they were the result of a county referral.

3. A county-owned clinic identifies a condition requiring treatment. The county-owned clinic refers the child to an EAPC clinic for treatment. The EAPC clinic provides treatment services.

   Billing: The clinic may bill CTP for treatment services, because the treatment was a result of a county referral.

4. A clinic that does not receive EAPC funds during that fiscal year identifies a condition requiring treatment. The non-EAPC clinic provides treatment services.

   Billing: The clinic may bill CTP for services provided, because the clinic does not have the obligation associated with the receipt of EAPC funds.

5. An EAPC clinic identifies a condition requiring treatment. The treatment needed is not within the scope of treatment services provided by the EAPC clinic. The EAPC clinic refers the child to a private provider or specialist to have the necessary treatment services provided.

   Billing: The private provider or specialist may bill CTP, because the EAPC clinic is only required to provide services insofar as the clinic directly provides those services for other patients.

6. An EAPC clinic identifies a condition requiring treatment. The EAPC clinic provides the treatment services.

   Billing: The EAPC clinic is obligated to provide treatment and is responsible for the financial cost. The CTP cannot be billed.

7. An EAPC clinic identifies a condition requiring treatment. The EAPC clinic provides treatment services. The clinic has exhausted all EAPC funds for the fiscal year.

   Billing: The EAPC clinic is still obligated to provide the treatment and is responsible for the financial cost. The obligation to treat CHDP children is not tied to the level or amount of funding provided by EAPC. The CTP cannot be billed.

8. A private CHDP provider identifies a condition requiring treatment. The private CHDP provider refers the child to an EAPC clinic for treatment. The EAPC clinic provides treatment services.

   Billing: The EAPC clinic is obligated to provide treatment and is responsible for the financial cost. The CTP cannot be billed.

EXPANDED ACCESS TO PRIMARY CARE (EAPC) PROGRAM
(FY 2002-2003)

CHDP GUIDELINES AND REPORTING PROCEDURES

CHDP mandate

As a condition of receiving EAPC funding, corporations participating in the EAPC program must comply with requirements of Health and Safety Code 124930, which mandates treatment and follow-up of conditions detected as part of a health screening under the Child Health and Disability Prevention (CHDP) Program, as follows:

124930. (a) For any condition detected as part of a child health and disability prevention screen for any child eligible for services under Section 104395, if the child was screened by the clinic or upon referral by a child health and disability prevention program provider, unless the child is eligible to receive care with no share of cost under the Medi-Cal program, is covered under another publicly funded program, or the services are payable under private coverage, a clinic shall, as a condition of receiving funds under this article, do all of the following:

(1) Insofar as the clinic directly provides these services for other patients, provide medically necessary follow up treatment, including prescription drugs.

(2) Insofar as the clinic does not provide treatment for the condition, arrange for the treatment to be provided.

(b) (1) If any child requires treatment the clinic does not provide, the clinic shall arrange for the treatment to be provided, and the name of that provider shall be noted in the patient's medical record.

(2) The clinic shall contact the provider or the patient or his or her guardian, or both, within 30 days after the arrangement for the provision of treatment is made, and shall determine if the provider has provided appropriate care, and shall note the results in the patient's medical record.

(3) If the clinic is not able to determine, within 30 days after the arrangement for the provision of treatment is made, whether the needed treatment was provided, the clinic shall provide written notice to the county child health and disability prevention program director, and shall also provide a copy to the state director of the program.

Continued on next page.

Continuation of services	Participants in the EAPC Program are responsible for providing treatment services, regardless of the availability of EAPC funding. That is, treatment must be provided even when the EAPC award is exhausted.
CTP reimbursement	EAPC program participants may not be eligible for county or state Children's Treatment Program (CTP) reimbursement under most circumstances. Reimbursement may be an alternative, if the initial assessment is provided and referral made by a CHDP provider other than the EAPC-participating clinic. (Refer to Enclosures C-2 and C-3 for further information)
CHDP reimbursement	The CHDP program must be billed for the initial CHDP assessment. Sliding fees may be charged for the treatment of conditions identified in the CHDP assessment. Sliding fees are not considered co-payments. The PM 160 form is the claim document for this purpose.
Reporting procedures	Clinics are required to report all CHDP patients for whom treatment was provided or arranged during FY 2002-2003. This information must be reported on the attached EAPC-CHDP Treatment Log (Enclosure C-4). Instructions to complete the log are noted on the back of the form. The logs should be completed monthly and mailed to the EAPC program quarterly as defined in the instructions on the back of the reporting log.
Documentation	A copy of the PM 160 form must be filed in the patient's medical record along with documentation of any referrals and follow-up, if applicable.

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY PETE WILSON, *Governor*

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
P.O. BOX 942732
SACRAMENTO, CA 94234-7320

March 5, 1997

TO: CLINIC EXECUTIVE DIRECTOR, CHILD HEALTH AND DISABILITY PREVENTION PROGRAM DIRECTOR, AND DEPUTY DIRECTOR

SUBJECT: EXPANDED ACCESS TO PRIMARY CARE CLINICS BILLING THE CHILDREN'S TREATMENT PROGRAM

The purpose of this letter is to identify the circumstances under which a clinic receiving Proposition 99 funds through the Expanded Access to Primary Care (EAPC) Program may seek reimbursement from the Children's Treatment Program (CTP).

The need for clarification of reimbursement for treatment of the Child Health and Disability Prevention (CHDP) Program arose as a result of the passage of Proposition 99 in 1988. In 1989, legislation was enacted that specified the use of Proposition 99 (Cigarette and Tobacco Surtax) funds. Included in this legislation was language know as the "CHDP Program Children's Treatment Mandate." This mandate stipulates that any county which receives Proposition 99 funds via the Hospital Services Account, Physician Services Account, and the Unallocated Account, and/or a primary care clinic which receives Proposition 99 funds is responsible for the treatment of a child that the CHDP health assessment identifies as having a medical or dental condition. The mandate also stipulates that the child is eligible only if the child/family does not have the means to pay for the necessary treatment services, private health insurance, or coverage under a publicly-funded program (e.g., Medi-Cal or California Children's Services).

Each EAPC clinic is responsible for providing medical and/or dental services to children who receive their CHDP health assessment at the EAPC clinic and to those children referred to the EAPC clinic from a private CHDP provider. The obligation for treatment services by the clinic is limited to

those services it directly provides to other patients. To clarify who is responsible for the payment of treatment services when a referral is made by a county, please refer to the following enclosure, which outlines various scenarios and the responsibilities of the parties in those situations.

If you have any questions concerning EAPC, please contact Ms. Sunni Burns, Chief of Expanded Access to Primary Care and Program Support Section, at (916) 657-0170. If you have any CHDP questions, please contact your local CHDP office. If you have any questions concerning CTP, please contact me at (916) 445-3194.

James M. Ford, Ph.D., Chief
Children's Treatment Program
Contract Back Unit
Program Support Section
Office of County Health Services

Enclosures

cc: Ms. Sunni Burns, Chief
Expanded Access to Primary Care Services
Department of Health Services
714 P Street, Room 576
P.O. Box 942732
Sacramento, CA 94234-7320

EAPC CLINIC SCREEN/TREATMENT/BILLING EXAMPLES

There are two assumptions made regarding the following examples:

1. The child meets all the statutory criteria for treatment.

2. The obligation for treatment services by the clinic is limited to those services it directly provides for other patients (e.g., if the clinic does not provide dental services it has no obligation to provide dental treatment).

1. The county instructs a private provider, in writing, to refer CHDP patients to an EAPC clinic when a condition that requires treatment is identified. The private provider is required to keep a copy of the "instruction" letter on file.

   Billing: The EAPC clinic may bill CTP for services rendered.

2. A private CHDP provider identifies a condition requiring treatment. The private CHDP provider refers the child to an EAPC clinic for treatment. However, the parent does not take the child in for the treatment needed. At a later date, the county CHDP Program contacts the parent and directs the child to an EAPC clinic for treatment as part of its case management responsibilities. The EAPC clinic provides treatment services.

   Billing: The EAPC clinic may bill CTP for treatment services, because they were the result of a county referral.

3. A county-owned clinic identifies a condition requiring treatment. The county-owned clinic refers the child to an EAPC clinic for treatment. The EAPC clinic provides treatment services.

   Billing: The clinic may bill CTP for treatment services, because the treatment was a result of a county referral.

4. A clinic that does not receive EAPC funds during that fiscal year identifies a condition requiring treatment. The non-EAPC clinic provides treatment services.

   Billing: The clinic may bill CTP for services provided, because the clinic does not have the obligation associated with the receipt of EAPC funds.

5. An EAPC clinic identifies a condition requiring treatment. The treatment needed is not within the scope of treatment services provided by the EAPC clinic. The EAPC clinic refers the child to a private provider or specialist to have the necessary treatment services provided.

   Billing: The private provider or specialist may bill CTP, because the EAPC clinic is only required to provide services insofar as the clinic directly provides those services for other patients.

6. An EAPC clinic identifies a condition requiring treatment. The EAPC clinic provides the treatment services.

   Billing: The EAPC clinic is obligated to provide treatment and is responsible for the financial cost. The CTP cannot be billed.

7. An EAPC clinic identifies a condition requiring treatment. The EAPC clinic provides treatment services. The clinic has exhausted all EAPC funds for the fiscal year.

   Billing: The EAPC clinic is still obligated to provide the treatment and is responsible for the financial cost. The obligation to treat CHDP children is not tied to the level or amount of funding provided by EAPC. The CTP cannot be billed.

8. A private CHDP provider identifies a condition requiring treatment. The private CHDP provider refers the child to an EAPC clinic for treatment. The EAPC clinic provides treatment services.

   Billing: The EAPC clinic is obligated to provide treatment and is responsible for the financial cost. The CTP cannot be billed.

EXPANDED ACCESS TO PRIMARY CARE (EAPC) PROGRAM

(FY 2002-2003)

CHILDREN'S TREATMENT PROGRAM (CTP)
Participating Contract-Back Counties

COUNTY NUMBER	COUNTY NAME
02	Alpine
03	Amador
04	Butte
05	Calaveras
06	Colusa
07	Del Norte
09	El Dorado
11	Glenn
12	Humboldt
13	Imperial
14	Inyo
16	Kings
17	Lake
18	Lassen
20	Madera
21	Marin
22	Mariposa

COUNTY NUMBER	COUNTY NAME
23	Mendocino
25	Modoc
26	Mono
28	Napa
29	Nevada
32	Plumas
35	San Benito
45	Shasta
46	Sierra
47	Siskiyou
49	Sonoma
51	Sutter
52	Tehama
53	Trinity
55	Tuolumne
58	Yuba

PLEASE DUPLICATE AS NEEDED

Enclosure C-4

EAPC-CHDP TREATMENT LOG FOR THE MONTH OF _____

Legal Corporation Name	Clinic Site Name	County

As a condition of receiving EAPC funding, corporations participating in the EAPC program must comply with the requirements of Health and Safety Code 124930, which mandates treatment and follow-up of conditions detected as part of a health screening under the CHDP Program. Please complete the information below.

CHDP TREATMENT STATISTICS:

1. TotalCHDP follow-up treatments provided on site:		2. Total CHDP follow-up treatments referred out:	

FOLLOW-UP ON CHDP PATIENTS REFERRED OUT:

	Patient ID Number	Indicate Medical (M)I or Dental (D)	Date Referred Out	Name of Referral Provider	Was treatment provided in 30 days? Y/N	If no, date written notice sent to County CHDP Director
1						
2						
3						
4						
5						
6						
7						

CHDP Coordinator/Contact	Telephone Number	DATE

(Rev. 09/02)

TREATMENT LOG INSTRUCTIONS

PROVIDER IDENTIFICATION (self explanatory)

CHDP ASSESSMENT STATISTICS

1. Provide the number of CHDP assessments during the month being reported.

REFERRAL STATISTICS: Below are the line item completion instructions for the referral statistics. (There may be several referrals from one assessment)

A. Enter the date the patient was seen for the CHDP assessment and referred to an outside provider for follow-up treatment, or the date the patient was treated at the clinic as a result of the CHDP screen performed by another CHDP provider or by the clinic.

B. Enter the patient's clinic identification number for audit purposes. Do **not** use a number that would easily identify the patient or the patient's name on this form.

C. Enter **"M"** if the screen identified a **Medical** condition, enter **"D"** if identified a **Dental** condition.

D. Enter **"I"** if the patient was referred to the clinic. Enter **"O"** if the patient was referred to an outside provider. Enter **"C"** if the patient was referred back to the clinic for treatment at a later date.

E. Enter the date of the appointment for treatment by the referred provider. If not available, enter the date of the initial clinic services.

F. Enter the name of the provider to whom the patient was referred for treatment.

G. Enter the date of contact with the provider, the patient, his/her guardian, or both patient and parent or guardian, to determine if the patient received appropriate treatment. If this date cannot be within 30 calendar days from the date in E, due to circumstance beyond the control of the clinic, such as limited appointment availability, an asterisk (*) may be entered and provide a brief explanation.

H. Enter **"Y"** if treatment was provided, or enter **"N"** if treatment was not provided. This information is based on the results of Column G. An asterisk may be entered if there is one in Column G.

I. Enter the date the required notice was mailed to the county and state CHDP Program Director.

CHDP Treatment Logs should be completed on a monthly basis and submitted quarterly. To the extent possible, submit logs according to the following time schedule:

QUARTERLY PERIOD	DUE DATE
July/August/September 2002	December 15, 2002
October/November/December 2002	February 15, 2003
January/February/March 2003	May 15, 2003
April/May/June 2003	August 15, 2003

Mail Treatment Logs to the following address:

Primary and Rural Health Care Systems Branch
Expanded Access to Primary Care Program
714 P Street, Room 550,
Sacramento, CA 95814.

***Do not attach copies** of the PM 160 Forms or any other correspondence.
*Forward a copy of this treatment log to your county and State CHDP Program Director on a quarterly basis.

EXPANDED ACCESS TO PRIMARY CARE (EAPC) PROGRAM

SAMPLE LETTER TO THE LOCAL CHDP PROGRAM DIRECTOR

Name of the Local CHDP Program Director
Title
Local Health Department
Address

Dear (Insert Name)

In order to receive funding under the Expanded Access to Primary Care (EAPC) Program under Health and Safety Code Section 124930, primary care clinics are required to report to their local Child Health and Disability Prevention (CHDP) Program all CHDP patients who were not treated within 30 days.

This is to notify you that the patient referenced below has not been treated within 30 days after being referred to another health care provider or requested to return to the clinic for treatment.

<table>
<tr><td colspan="2">Name of Patient</td><td>Date of Birth</td><td>Language Spoken</td></tr>
<tr><td colspan="2">Name of Parent of Guardian</td><td>Address</td><td>Telephone Number</td></tr>
<tr><td>Patient Identification Number</td><td>Date of Referral</td><td colspan="2">Name of Provider to whom Referred</td></tr>
<tr><td colspan="4">Reason for Referral</td></tr>
<tr><td colspan="4">Briefly describe reason treatment has been delayed.
_____
_____
_____</td></tr>
</table>

If you have any questions, please call (name of clinic contact at (telephone number.)

Sincerely,

Clinic Medical Director or representative.

CALIFORNIA CODES
HEALTH AND SAFETY CODE
SECTION 124900-124945

124900. (a) (1) The State Department of Health Services shall select primary care clinics that are licensed under paragraph (1) or (2) of subdivision (a) of Section 1204, or are exempt from licensure under subdivision (c) of Section 1206, to be reimbursed for delivering medical services, including preventative health care, and smoking prevention and cessation health education, to program beneficiaries.

(2) Except as provided for in paragraph (3), in order to be eligible to receive funds under this article a clinic shall meet all of the following conditions, at a minimum:

(A) Provide medical diagnosis and treatment.

(B) Provide medical support services of patients in all stages of illness.

(C) Provide communication of information about diagnosis, treatment, prevention, and prognosis.

(D) Provide maintenance of patients with chronic illness.

(E) Provide prevention of disability and disease through detection, education, persuasion, and preventive treatment.

(F) Meet one or both of the following conditions:

(i) Are located in an area federally designated as a medically underserved area or medically underserved population.

(ii) Are clinics that are able to demonstrate that at least 50 percent of the patients served are persons with incomes at or below 200 percent of the federal poverty level.

(3) Notwithstanding the requirements of paragraph (2), all clinics that received funds under this article in the 1997-98 fiscal year shall continue to be eligible to receive funds under this article.

(b) As a part of the award process for funding pursuant to this article, the department shall take into account the availability of primary care services in the various geographic areas of the state. The department shall determine which areas within the state have populations which have clear and compelling difficulty in obtaining access to primary care. The department shall consider proposals from new and existing eligible providers to extend clinic services to these populations.

(c) Each primary care clinic applying for funds pursuant to this article shall demonstrate that the funds shall be used to expand medical services, including preventative health care, and smoking

prevention and cessation health education, for program beneficiaries above the level of services provided in the 1988 calendar year or in the year prior to the first year a clinic receives funds under this article if the clinic did not receive funds in the 1989 calendar year.

(d) (1) The department, in consultation with clinics funded under this article, shall develop a formula for allocation of funds available. It is the intent of the Legislature that the funds allocated pursuant to this article promote stability for those clinics participating in programs under this article as part of the state's health care safety net and at the same time be distributed in a manner that best promotes access to health care to uninsured populations.

(2) The formula shall be based on both of the following:

(A) A hold harmless for clinics funded in the 1997-98 fiscal year to continue to reimburse them for some portion of their uncompensated care.

(B) Demonstrated unmet need by both new and existing clinics, as reflected in their levels of uncompensated care reported to the department. For purposes of this article, "uncompensated care" means clinic patient visits for persons with incomes at or below 200 percent of the federal poverty level for which there is no encounter-based third-party reimbursement which includes, but is not limited to, unpaid expanded access to primary care claims and other unreimbursed visits as verified by the department according to subparagraph (A) of paragraph (5).

(3) In the 1998-99 fiscal year, the department shall allocate funds for a three-year period as follows:

(A) If the funds available for the purposes of this article are equal to or less than the prior fiscal year, clinics that received funding in the prior fiscal year shall receive 90 percent of their prior fiscal year allocation, subject to available funds, provided that funding award is substantiated by the clinics' reported levels of uncompensated care. The remaining funds beyond 90 percent shall be awarded in the following order:

(i) First priority shall be given to clinics that participated in the program in prior fiscal years, withdrew from the program due to financial considerations, were subsequently categorized as "new applicants" when they reapplied to the program, and received a significantly reduced allocation as a result. These clinics shall be awarded 90 percent of their allocation prior to their withdrawal from the program, subject to available funds, provided that award level is substantiated by the clinic's reported levels of uncompensated care.

(ii) Second priority shall be given to those clinics that received program funds in the prior year and continue to meet the minimum

requirements for funding under this article. In implementing this priority, the department shall allocate funds to all eligible previously funded clinics on a proportionate basis, based on their reported levels of uncompensated care, which may include, but is not limited to, unpaid expanded access to primary care claims and other unreimbursed patient visits, as verified by the department according to subparagraph (A) of paragraph (5).

(B) If funds available for the purposes of this article are equal to or less than the prior fiscal year, only those clinics that received program funds in the prior fiscal year may be awarded funds. Funds shall be awarded in the same priority order as specified in clauses (i) and (ii) of subparagraph (A).

(C) If funds available for purposes of this article are greater than the prior fiscal year, clinics that received funds in the prior fiscal year shall be awarded 100 percent of their prior fiscal year allocation, provided that funding award level is substantiated by the clinic's reported levels of uncompensated care. Remaining funds shall be awarded in the following priority order:

(i) First priority shall be given to clinics that participated in the program in prior fiscal years, withdrew from the program due to financial considerations, were subsequently categorized as "new applicants" when they reapplied to the program, and received a significantly reduced allocation as a result. These clinics shall be awarded 100 percent of their allocation prior to their withdrawal from the program, provided that award level is substantiated by the clinic's reported levels of uncompensated care.

(ii) Second priority shall be given to new and existing applicants that meet the minimum requirements for funding under this article. In implementing this priority, the department shall allocate funds to all eligible previously funded clinics on a proportionate basis, based on their reported levels of uncompensated care, which may include, but is not limited to, unpaid expanded access to primary care claims and other unreimbursed patient visits, as verified by the department, according to subparagraph (A) of paragraph (5).

(4) In the 2001-02 fiscal year, and subsequent fiscal years, the department shall allocate available funds, for a three-year period, as follows:

(A) Clinics that received funding in the prior fiscal year shall receive 90 percent of their prior fiscal year allocation, subject to available funds, provided that the funding award is substantiated by the clinics' reported levels of uncompensated care.

(B) The remaining funds beyond 90 percent shall be awarded to new and existing applicants based on the clinic's reported levels of uncompensated care as verified by the department according to subparagraph (B) of paragraph (5). The department shall seek input from stakeholders to discuss any adjustments to award levels that the

department deems reasonable such as including base amounts for new applicant clinics.

(C) New applicants shall be awarded funds pursuant to this subdivision if they meet the minimum requirements for funding under this article based on the clinics' reported levels of uncompensated care as verified by the department according to subparagraph (B) of paragraph (5). New applicants include applicants for any new site expansions by existing applicants.

(D) The department shall confer with clinic representatives to develop a funding formula for the program implemented pursuant this paragraph to use for allocations for the 2004-05 fiscal year and subsequent fiscal years.

(E) This paragraph shall become inoperative on July 1, 2004.

(5) In assessing reported levels of uncompensated care, the department shall utilize the most recent data available from the Office of Statewide Health Planning and Development's (OSHPD) completed analysis of the "Annual Report of Primary Care Clinics."

(A) In the 1998-99 to 2000-01 fiscal years, inclusive, clinics shall submit updated data regarding the clinic's levels of uncompensated care to the department with their initial application, and for each of the two remaining years in the three-year application period. The department shall compare the clinic's updated uncompensated care data to the OSHPD uncompensated care data for that clinic for the same reporting period. Discrepancies in uncompensated care data for any particular clinic shall be resolved to the satisfaction of the department prior to the award of funds to that clinic.

(B) In the 2001-02 fiscal year, and subsequent fiscal years, clinics may not submit updated data regarding the clinic's levels of uncompensated care. The department shall utilize the most recent data available from OSHPD's completed analysis of the "Annual Report of Primary Care Clinics."

(C) If the funds allocated to the program are less than the prior year, the department shall allocate available funds to existing program providers only.

(6) The department shall establish a base funding level, subject to available funds, of no less than thirty-five thousand dollars ($35,000) for frontier clinics and Native American reservation-based clinics. For purposes of this article, "frontier clinics" means clinics located in a medical services study area with a population of fewer than 11 persons per square mile.

(7) The department shall develop, in consultation with clinics funded pursuant to this article, a formula for reallocation of unused funds to other participating clinics to reimburse for uncompensated care. The department shall allocate the unused funds to other participating clinics to reimburse for uncompensated care.

(e) In applying for funds, eligible clinics shall submit a single application per clinic corporation. Applicants with multiple sites shall apply for all eligible clinics, and shall report to the department the allocation of funds among their corporate sites in the prior year. A corporation may only claim reimbursement for services provided at a program-eligible clinic site identified in the corporate entity's application for funds, and approved for funding by the department. A corporation may increase or decrease the number of its program-eligible clinic sites on an annual basis, at the time of the annual application update for the subsequent fiscal years of any multiple-year application period.

(f) Grant allocations pursuant to this article shall be based on the formula developed by the department, notwithstanding a merger of one of more licensed primary care clinics participating in the program.

(g) A clinic that is eligible for the program in every other respect, but that provides dental services only, rather than the full range of primary care medical services, shall only be eligible to receive funds under this article on an exception basis. A dental-only provider's application shall include a Memorandum of Understanding (MOU) with a primary care clinic funded under this article. The MOU shall include medical protocols for making referrals by the primary care clinic to the dental clinic and from the dental clinic to the primary care clinic, and ensure that case management services are provided and that the patient is being provided comprehensive primary care as defined in subdivision (a).

(h) (1) For purposes of this article, an outpatient visit shall include diagnosis and medical treatment services, including the associated pharmacy, X-ray, and laboratory services, and prevention health and case management services that are needed as a result of the outpatient visit. For a new patient, an outpatient visit shall also include a health assessment encompassing an assessment of smoking behavior and the patient's need for appropriate health education specific to related tobacco use and exposure.

(2) "Case management" includes, for this purpose, the management of all physician services, both primary and specialty, and arrangements for hospitalization, postdischarge care, and followup care.

(i) (1) Payment shall be on a per visit basis at a rate that is determined by the department to be appropriate for an outpatient visit as defined in this section, and shall be not less than seventy-one dollars and fifty cents ($71.50).

(2) In developing a statewide uniform rate for an outpatient visit as defined in this article, the department shall consider existing rates of payments for comparable outpatient visits. The department shall review the outpatient visit rate on an annual basis.

(j) Not later than May 1 of each year, the department shall adopt and provide each licensed primary care clinic with a schedule for programs under this article, including the date for notification of availability of funds, the deadline for the submission of a completed application, and an anticipated contract award date for successful applicants.

(k) In administering the program created pursuant to this article, the department shall utilize the Medi-Cal program statutes and regulations pertaining to program participation standards, medical and administrative recordkeeping, the ability of the department to monitor and audit clinic records pertaining to program services rendered to program beneficiaries and take recoupments or recovery actions consistent with monitoring and audit findings, and the provider's appeal rights. Each primary care clinic applying for program participation shall certify that it will abide by these statutes and regulations and other program requirements set forth in this article.

124905. For purposes of this article, a "program beneficiary" is any person whose income level is at or below 200 percent of the federal poverty level as adjusted annually. Program beneficiaries shall not be required to provide any copayment for services that are funded pursuant to this article, except that clinics may charge beneficiaries on a sliding fee scale for services, but no beneficiary shall be denied services because of an inability to pay. The department shall annually adjust this income standard to reflect any changes in the federal poverty level. Payment pursuant to this article shall be made only for services for which payment will not be made through any private or public third-party reimbursement.

124906. A program applicant's uncompensated care shall be determined by, and based on, the number of visits for patients whose income level is at or below 200 percent of the federal poverty level, and whose health care costs are not reimbursed by any encounter-based third-party payer, which includes, but is not limited to, unpaid expanded access to primary care claims or other unreimbursed visits, as verified by the department according to subparagraph (A) of paragraph (5) of subdivision (d) of Section 124900.

124910. (a) (1) Except as provided in paragraph (3) of subdivision (a) of Section 124900, each licensed primary care clinic, as specified in subdivision (a) of Section 124900, applying for funds under this article, shall demonstrate in its application that it meets all of the following conditions, at a minimum:

(A) Provides medical diagnosis and treatment.

(B) Provides medical support services of patients in all stages of illness.

(C) Provides communication of information about diagnosis, treatment, prevention, and prognosis.

(D) Provides maintenance of patients with chronic illness.

(E) Provides prevention of disability and disease through detection, education, persuasion, and preventive treatment.

(F) Meets one or both of the following conditions:

(i) Is located in an area federally designated as a medically underserved area or medically underserved population.

(ii) Is a clinic in which at least 50 percent of the patients served are persons with incomes at or below 200 percent of the federal poverty level.

(2) Any applicant who has applied for and received a federal or state designation for serving a medically underserved area or population shall be deemed to meet the requirements of subdivision (a) of Section 124900.

(b) Each applicant shall also demonstrate to the satisfaction of the department that the proposed services supplement, and do not supplant, those primary care services to program beneficiaries that are funded by any county, state, or federal program.

(c) Each applicant shall demonstrate that it is an active Medi-Cal provider by having a Medi-Cal provider number and diligently billing the Medi-Cal program for services rendered to Medi-Cal eligible patients during the past three months. This subdivision shall not apply to clinics that are not currently Medi-Cal providers, and were funded participants pursuant to this article during the 1993-94 fiscal year.

(d) Each application shall be evaluated by the state department prior to funding to determine all of the following:

(1) The number of program beneficiaries who are in the service area of the applicant, and the number of visits, the scope of primary care services, and the proposed total budget for outpatient visits provided to beneficiaries under this article. The applicant shall provide its most recently audited financial statement to verify budget information.

(2) The applicant's ability to deliver basic primary care to program beneficiaries.

(3) A description of the applicant's operational quality assurance program.

(4) The applicant's use of protocols for the most common diseases in the population served under this article.

124911. (a) Commencing in the 1998-99 fiscal year, the department shall release a request for allocation of funds for a period of three succeeding fiscal years. The request for allocation shall include specifications for the clinics to submit uniform data on uncompensated patient visits.

(b) Annual funding awards for a clinic provider in the second and third fiscal years of a three-year funding period shall be contingent upon the clinic's satisfactory performance under the program, and upon the availability of sufficient funds appropriated by the annual Budget Act.

124915. Services funded pursuant to this article shall be limited to the extent that funds are appropriated for this purpose.

124920. (a) The department shall utilize existing contractual claims processing services in order to promote efficiency and to maximize use of funds.

(b) The department shall certify which primary care clinics are selected to participate in the program for each specific fiscal year, and how much in program funds each selected primary care clinic will be allocated each fiscal year.

(c) The department shall make an advance payment for funds appropriated for services provided under this article to the selected primary care clinics in an amount not to exceed 25 percent of a clinic's allocation for visits provided to program beneficiaries. These advance payments may only be made during the 1994-95 fiscal year.

(d) In the event the department's contractual claims processing service is not ready to accept and timely adjudicate program claims by August 15, 1994, the department shall reimburse clinic billings in excess of the advance payment until such time as the contractual claims processing mechanism is viable.

(e) The department shall pay claims from selected primary care clinics up to each clinic's annual allocation, adjusted for advance payments made under subdivision (c) and claims reimbursement made under subdivision (d). Once a clinic has exhausted its annual

allocation, the state shall stop paying its program claims.

(f) The department may adjust any selected primary care clinic's allocation to take into account:

(1) An increase in program funds appropriated for the fiscal year.

(2) A decrease in program funds appropriated for the fiscal year.

(3) A clinic's projected inability to fully spend its allocation within the fiscal year.

(4) Surplus funds reallocated from other selected primary care clinics.

(g) The department shall notify all affected primary care clinics in writing prior to adjusting selected primary care clinics' allocations.

(h) Cessation of program payments under subdivision (e) or adjustment of selected primary care clinic's allocations under subdivision (f) shall not be subject to the Medi-Cal appeals process referenced in subdivision (g) of Section 124900.

(i) A clinic's allocation under this article shall not be reduced solely because the clinic has engaged in supplemental fundraising drives and activities, the proceeds of which have been used to defray the costs of services to the uninsured.

124925. The department shall submit a report on its activities under this article to the Legislature no later than January 1, 1991, and annually thereafter.

124927. Final payment adjustments reflecting advance payments pursuant to this article shall be made pursuant to a plan of financial adjustment that is approved by the state department and submitted to the Controller.

124930. (a) For any condition detected as part of a child health and disability prevention screen for any child eligible for services under Section 104395, if the child was screened by the clinic or upon referral by a child health and disability prevention program provider, unless the child is eligible to receive care with no share of cost under the Medi-Cal program, is covered under another publicly funded program, or the services are payable under private coverage, a clinic shall, as a condition of receiving funds under this article, do all of the following:

(1) Insofar as the clinic directly provides these services for other patients, provide medically necessary followup treatment, including prescription drugs.

(2) Insofar as the clinic does not provide treatment for the condition, arrange for the treatment to be provided.

(b) (1) If any child requires treatment the clinic does not provide, the clinic shall arrange for the treatment to be provided, and the name of that provider shall be noted in the patient's medical record.

(2) The clinic shall contact the provider or the patient or his or her guardian, or both, within 30 days after the arrangement for the provision of treatment is made, and shall determine if the provider has provided appropriate care, and shall note the results in the patient's medical record.

(3) If the clinic is not able to determine, within 30 days after the arrangement for the provision of treatment is made, whether the needed treatment was provided, the clinic shall provide written notice to the county child health and disability prevention program director, and shall also provide a copy to the state director of the program.

(c) (1) For the 1994-95 and 1995-96 fiscal years, inclusive, the state department may establish a reimbursement program for referral case management services required pursuant to subdivision (b), provided to a child pursuant to subdivision (a).

(2) The department may utilize funds appropriated for the purposes of this article for reimbursements under paragraph (1).

124940. The use of funds granted pursuant to this article for use by school-based clinics shall be limited to those school-based clinics that were licensed and in operation before January 1, 1990.

124945. Any entity or provider that receives funds pursuant to this article shall expend those funds in accordance with the requirements of Article 2 (commencing with Section 30121) of Chapter 2 of Part 13 of Division 2 of the Revenue and Taxation Code.